REQUEST FOR MEDICARE PAYMENT - AMBULANCE
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

(SEE INSTRUCTIONS ON BACK - TYPE OR PRINT INFORMATION)

FORM APPROVED
OMB No. 0938-0042

PART I - PATIENT TO FILL IN ITEMS 1 THROUGHT 6 ONLY

No Part B Medicare benefits may be paid unless a completed application form has been received as required by existing law and regulations (20 C.F.R. 400.26f).
NOTICE - Anyone who misrepresents or falsfies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

COPY FROM YOUR OWN HEALTH INSURANCE CARD *(See Example on Back)*

1 Name of Patient *(First Name, Middle Initial, Last Name)*

2 Health Insurance Claim No.

☐ Male ☐ Female

3 Patient's complete mailing address *(including Apt. No.) City, State, ZIP Code*

Telephone Number

4 Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below

Name and address of organization or agency

Policy or Identification Number

Note: If you DO NOT want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Adminstration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either to myself or to the party who accepts assignment below.

Signature of patient *(See instructions on reverse where patient is unable to sign)*
SIGN HERE ➡

Date signed

PART II - AMBULANCE SUPPLIER TO FILL IN 7 THROUGH 25

7. Date of Service

☐ Emergency ☐ Admission
☐ Discharge ☐ Outpatient Visit

8. Ordered by

9. Description of Illness or Injury *(Describe factors which made ambulance transportation necessary)*

10. Name of Treating Doctor

11. Address of Doctor

12. Origin of Service

13. Destination of Service

14. Number of Miles

15. Cost per Mile

16. Mileage Charge

22. Describe special service *(If none leave blank)*

17. Base Rate

18. Spec. Serv. Chg. *(Desc. Item 22)*

23. Name and Address of Supplier *(Number and Street, City, State, Zip Code)*

Supplier Code

19. Total Charges

20. Amount Paid

Telephone Number

21. Any Unpaid Balance Due

24. Assignment of Patient's Bill
☐ I accept assignment *(See reverse)* ☐ I do not accept assignment

25. Signature of Supplier

Date Signed

SOME THINGS TO NOTE IN FILLING OUT PART I

(Your supplier will fill out Part II).

& Copy the name and number and indicate your sex exactly as shown on your health insurance card, Include the letters at the end of the number.

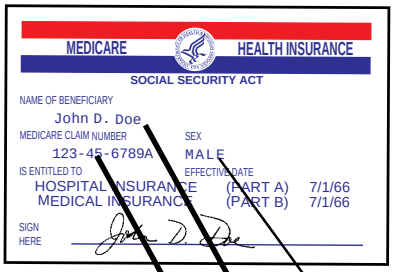
Enter your mailing address and telephone number, if any.

Be sure to check one of the two boxes.

If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

Be sure to sign your name. If you cannot write your name, sign by mark (X), and have a witness sign his/her name and enter his/her address on this line.

If the claim is filed for the patient by another person, he or she should enter the patient's name and write "By," sign his/her own name and address in this space, show his/her relationship to the patient,and why the patient cannot sign (If the patient has died, the survivor should contact any social security office for information on what to do).


MEDICARE HEALTH INSURANCE
SOCIAL SECURITY ACT
NAME OF BENEFICIARY
John D. Doe
MEDICARE CLAIM NUMBER
123-45-6789A
SEX
MALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL INSURANCE (PART A) 7/1/66
MEDICAL INSURANCE (PART B) 7/1/66
SIGN HERE
John D. Doe

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PART I - PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

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NOTICE - Anyone who misrepresents or falsfies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

COPY FROM YOUR OWN HEALTH INSURANCE CARD *(See Example on Back)*

1 Name of Patient *(First Name, Middle Initial, Last Name)*

2 Health Insurance Claim No. ☐ Male ☐ Female

3 Patient's complete mailing address *(including Apt. No.) City, State, ZIP Code* | Telephone Number

4 Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below
Name and address of organization or agency | Policy or Identification Number

Note: If you DO NOT want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Adminstration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either to myself or to the party who accepts assignment below.

Signature of patient *(See instructions on reverse where patient is unable to sign)* SIGN HERE ➡ | Date signed

PART II - AMBULANCE SUPPLIER TO FILL IN 7 THROUGH 25

7. Date of Service ☐ Emergency ☐ Admission ☐ Discharge ☐ Outpatient Visit | 8. Ordered by

9. Description of Illness or Injury *(Describe factors which made ambulance transportation necessary)*

10. Name of Treating Doctor | 11. Address of Doctor

12. Origin of Service | 13. Destination of Service

14. Number of Miles | 15. Cost per Mile | 16. Mileage Charge

22. Describe special service *(If none leave blank)* | 17. Base Rate | 18. Spec. Serv. Chg. *(Desc. Item 22)*

23. Name and Address of Supplier *(Number and Street, City, State, Zip Code)* | Supplier Code | 19. Total Charges | 20. Amount Paid | Telephone Number | 21. Any Unpaid Balance Due

24. Assignment of Patient's Bill ☐ I accept assignment *(See reverse)* ☐ I do not accept assignment

25. Signature of Supplier | Date Signed

Form HCFA-1491(2)(1-80) Department of Health and Human Services - Health Care Financing Adminstration

IMPORTANT NOTES FOR PHYSICIAN AND SUPPLIERS

Item 24: In assigned cases the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge the carrier determines to be "reasonable" if this is less than the charge submitted.

If the physician or supplier does not want Part II information released to the organization named in item 5, he or she should write "No further release" in Item 22.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended. The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workmen's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.